Oriental insurance

PRITHVI, AGNI, JAL, AKASH SAB KI SURAKSHA HAMARE PAAS

CLAIM FORM FOR NIRAMAYA HEALTH INSURANCE SCHEME

Notes: This form is issued without admission of liability and must be completed and returned to the insurance company for processing the claim.

Claim No (to be allotted by the insurer):_____Policy No:_____

1. Details of the Claimant:

Name in Full:_____

Present Age: _____Years, Relationship with the patient_____

Telephone No.: _____

Residential Address: _____

_____

_____

2. Details of the Patient:

Name in Full:_____ Age:_____ Years, Disability:_____

Son/Daughter of:_____ BPL Card No. _____

Residential Address: _____

_____

3. Permanent Business or Occupation:(If more than one state all)

_____

4. (a) Name & address of the hospital where the treatment was conducted:

_____

_____

(b) Name, address & ..... who conducted the treatment

_____

_____

5. Nature of claim :OPD/ IPD/ Therapy

a) Date/s: _____

b) Details of disease: ___ _____

c) Date of Admission: _____Time: _____

d) Date of Discharge: _____Time: _____

6. Total Claimed Amount : _____

7. If the claim is for domiciliary hospitalization, please indicate:

a) Date of commencement of treatment : _____

b) Date of completion of treatment : _____

c) Name & address of attending Medical Practitioner : _ _____

d) Qualification : _____

e) Telephone No. : _____

8. Are you insured elsewhere? If so, give details:

a) Name of the Company and Sum Insured: _____

b) The amount you are entitled to Claim under above policy: _____

In support of the above claim, I enclose following documents {Please indicate by (□)}

1. Bills, Receipt and Discharge Certificate/card from the Hospital/Nursing Home.(In original)
2. CashmemosfromtheHospital/Chemist(s),supportedbytheproperprescription.(Inorigina
3. Receipt and Pathological test reports from a Pathologist supported by the note from the attending Medical Practitioner/ Surgeon demanding such Pathological tests.(In Original)
4. Surgeons certificate stating nature of operation performed and surgeon's bill and receipt. (In Original)
5. Attending Doctor's/Consultant's/Specialist's/Anesthetist's bill and receipt and certificate regarding diagnosis, whichever is prescribed & thereby expenses incurred (In Original)
6. If any transportation bill then pls. submit the bill. (In original)

Declaration:

I HEREBY DECLARE that the particulars are true to best of my knowledge and warrant the truth of the foregoing particulars in every respect, and I agree that if I have made, or if shall make any false or untrue statement, suppression or concealment, my right to compensation shall be absolutely forfeited.

Place:
Date: Signature of Insured

MANDATORY

Part - C-NEFT (For Direct Fund Transfer/ Electronic Fund Transfer)

As per IRDA Circular No.: IRDA/F&A/CIR/GLD/056/02/2014, Proposer's/ policy holder's bank account details are mandatory to process the claim through EFT, please provide the below details (all fields are compulsory) and provide a cancelled cheque of the proposer/ policy holder (should be of the bank account number mentioned below)

- Proposer/ policy holder name* (as per bank records)
- Proposer/ policy holder account no.:
- Name of the bank:
- Branch name:
- Address of the bank:
- IFSC code no. of the bank: (should be same as per the provided cheque leaflet)
- PAN card no. of Proposer/ policy holder: (Permanent Account Number)

Please provide an **Original Blank Cancelled Cheque** signed by the Proposer/ policy holder, which is mandatory for processing the claim.

_____
Account holder's Signature

Note: Claim Form under Niramaya All Claims for settlement under Niramaya has to be submitted in the prescribed Claim Form along with relevant vouchers/bills, etc. with 30 days of treatment or discharge from hospital.

Mailing Address : **RAKSHA TPA Pvt. Ltd. J&Co Chambers, Manimala Road, Near Ganapathy Temple, Edappally, Cochin-682024. Ph: 0484 4000506**